

THIS ISSUE

Coverage Decisions
(October 2004 to
December 2004)

TO:

Anesthesiologists
Chiropractors
Neurologists
Neurosurgeons
Nursing Home and Residential
Care Facilities
Occupational Medicine
Physicians
Orthopedic surgeons
Physical Medicine and
Rehabilitation Physicians
Physical Therapists
Physicians
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Purpose

This Provider Bulletin describes recent coverage decisions from the Office of the Medical Director.

The following coverage decisions are effective on March 1, 2005, and pertain to State Fund and Self-Insured employers in all locations.

- Botulinum toxin
- Electrical stimulation
- Hyperbaric oxygen therapy
- Negative pressure wound therapy or Wound Vacuum Assisted Closure (VAC)

The non-coverage decision on Artificial Discs is currently in effect and pertains to State Fund claims and Self-Insured employers in all locations. For self insured claims, contact the self insured employer or their representative.

Botulinum Toxin

Botulinum toxins (BTX) prevent synaptic transmission of acetylcholine resulting in muscle paralysis.

BTX injections are used to reduce spasticity or excessive muscular contractions. The injections are intended:

- To relieve pain
- To assist in posturing and walking
- To allow better range of motion
- To permit better physical therapy outcomes

The Food and Drug Administration has approved two BTX products:

BTX Product	FDA Approved Indications
Botox (BTX – A)	Cervical dystonia, glabellar frown lines, primary axillary hyperhidrosis, strabismus
Myobloc (BTX – B)	Cervical dystonia

Coverage Decision

Botulinum toxin injections are covered for the following indications and with prior authorization.

Covered Indications

The insurer will cover BTX for the following indications when it is proper and necessary treatment.

- Blepharospasm
- Cervical dystonia (spasmodic torticollis)
- Hemifacial spasm
- Laryngeal or spasmodic dysphonia
- Orofacial dyskinesia
- Oromandibular dystonia
- Primary axillary hyperhidrosis
- Strabismus
- Torsion dystonia (idiopathic/symptomatic)
- Torticollis, unspecified
- Writer's cramp

Non-covered Indications

The department will not authorize payment for BTX injections for other off-label indications. The evidence has not sufficiently shown the safety and efficacy of BTX for headaches, other movement disorders, or chronic low back and neck pain.

Prior Authorization Criterion

Patients have not responded to conservative treatments, such as medication and physical therapy, used to control and/or treat covered indications.

Criteria for Additional Injections

The insurer may authorize one subsequent injection session administered 90 days after the initial session if the first BTX session produced an adequate, functional response. Physicians must submit documents describing the patient's response to BTX following a session of injections.

No more than 2 injections per individual will be authorized due to risk of antibody development and decrease in response.

Billing Codes

HCPCS Code	Description
J0585	Botulinum toxin type A, per unit (Botox)
J0587	Botulinum toxin type B, per 100 units (Myobloc)

Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing via angiogenesis promotion, collagen synthesis, and epithelial cell migration.

In this technique, one electrode is placed on the skin near the wound and the other electrode is applied to saline-moistened gauze over the wound. As a conductive medium, saline allows the electric current to pass through the wound.

Four classes of devices are used and differentiated by type of current:

1. Low – intensity direct current (LIDC)
2. High voltage pulsed current (HVPC)
3. Alternative current (AC)
4. Transcutaneous electrical nerve stimulation (TENS)¹

Coverage Decision

Electrical stimulation is covered for the following chronic wound indications. Prior authorization is required if electrical stimulation is requested for use on an outpatient basis.

Covered Indications

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

Prior Authorization Criteria

Prior authorization is required when electrical stimulation for chronic wounds is requested for use on an outpatient basis.

Electrical stimulation will be authorized if the wound has not improved following 30 days of standard wound therapy. In addition to electrical stimulation, standard wound care must continue.

Criterion for Continuing Treatment Beyond 30 Days

In order for payment for electrical stimulation to continue beyond 30 days, licensed medical personnel must provide documentation of wound measurements that demonstrate improvement has occurred within the past 30 days.

Billing Codes

HCPCS Code	Description
G0281	Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care.

¹ The department has contracted with one vendor, PMI, to dispense TENS units. For more information, please see the section on Professional Services Payment Policies in the Medical Aid Rules and Fee Schedule. The fee schedule is available on line at <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/default.asp>.

Hyperbaric Oxygen Therapy for Chronic Wounds

Hyperbaric oxygen therapy involves administering pure oxygen under pressures greater than 1 atmosphere in a specialized chamber. The elevated concentration and pressure of the oxygen in a hyperbaric chamber allows higher levels of oxygen absorption by blood. The goal is to promote tissue healing through a combination of increased hydrostatic pressure and elevation of the tissue oxygen tension.

Therapy is usually provided for one to two hours under hyperbaric conditions, and patients typically require 10 to 60 therapy sessions. It is delivered in single person or multiple person chambers.

Coverage Decision

Hyperbaric Oxygen Therapy is a covered therapy for the following chronic wound indications and with prior authorization.

Covered Indications

- Type I or II diabetic wounds of the lower extremities
- Wound is Wagner grade 3 or higher

Prior Authorization Criteria

Hyperbaric oxygen therapy will be authorized if the wound has not improved following 30 days of standard wound therapy. In addition to Hyperbaric oxygen therapy, standard wound care must continue.

Criterion for Continuing Treatment Beyond 30 Days

In order for payment for hyperbaric oxygen therapy to continue beyond 30 days, licensed medical personnel must provide documentation of wound measurements that demonstrate improvement has occurred within the past 30 days.

Billing Codes

CPT and HCPCS Codes	Description
99183	Physician attendance and supervision of hyperbaric oxygen therapy, per session
C1300	Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval (hospital only)

Negative Pressure Wound Therapy or VAC

Negative pressure wound therapy (NPWT) provides an environment of subatmospheric pressure to create a controlled, closed wound. The goals of NPWT include promoting granulation tissue formation and closing wounds by applying controlled, localized negative pressure.

The one negative pressure wound therapy device approved in the U.S. is Vacuum Assisted Closure (VAC). VAC consists of an evacuation tube embedded in a foam dressing. The foam dressing is placed within the wound bed and covered by an occlusive dressing to form a seal. Negative pressure is applied causing the foam to collapse. The resultant forces are distributed across the wound surfaces. Wound effluent is drawn through the evacuation tube into a collection canister.

Coverage Decision

Negative pressure wound therapy, or Wound Vacuum Assisted Closure (Wound VAC), is covered for chronic, acute, or traumatic wound indications. Prior authorization is required when negative pressure wound therapy is requested for outpatient use.

Covered Indications

- Stage III and IV pressure ulcers
- Neuropathic ulcers
- Venous or arterial insufficiency ulcers
- Ulcers of mixed etiology present for at least 30 days
- Dehisced wounds or wounds with exposed orthopedic hardware or bone
- Poststernotomy mediastinitis

Non-Covered Indications

- Osteomyelitis (untreated)
- Non-enteric and unexposed fistula
- Malignancy in the wound margins
- Exposed blood vessels or arteries
- Necrotic tissue

Prior Authorization Criteria

Prior authorization is required when negative pressure wound therapy is requested for outpatient use.

Negative pressure wound therapy for chronic wounds will be authorized if the wound has not improved following 30 days of standard wound therapy. In addition to negative pressure wound therapy, standard wound care must continue.

Maximum Coverage per Month

Payment is limited to 15 dressing kits per wound per month, unless the wound size requires more than one dressing kit per dressing change. Payment is limited to 10 canister sets per month unless there is a large volume of drainage (>90 ml exudates per day).

Criterion for Continuing Treatment Beyond 30 Days

In order for payment for negative pressure wound therapy to continue beyond 30 days, licensed health care personnel must provide documentation of wound measurements that demonstrate improvement has occurred with the past 30 days.

Billing Codes

HCPCS Code	Description
E2402	Negative pressure wound therapy electrical pump, stationary or portable
A6550	Dressing set for negative pressure wound therapy electrical pump, each
A6551	Canister set for negative pressure wound therapy electrical pump, each

Artificial Discs for Degenerative Disc Disease

The new surgical option of artificial disc replacement is intended to address pain due to degenerative disc disease. Theories regarding potential efficacy suggest that: 1) disc replacement may preserve motion as well as increase or restore motion, and 2) maintaining motion may protect against future degeneration at adjacent levels.

Two categories of artificial disc replacement devices are currently in use: intervertebral prostheses and disc nucleus replacements. Nucleus replacement products are designed for moderate degeneration while intervertebral prostheses are indicated for more severe degeneration.

Type	Name	Materials
Intervertebral prosthesis	Charite III	- high molecular weight polyethylene cast cobalt chromium molybdenum alloy (CoCrMoy) articulating bearing surface - titanium calcium phosphorous porous ingrowth surface
Intervertebral prosthesis	ProDisc II	- convex polyethylene component articulating with a concave metal component - metal endplates are made of CoCrMoy
Nucleus replacement	PDN	- hydrogel pellet encase in a polyethylene jacket - high molecular weight and linear polyethylene fibers surround pellet - pellets have platinum iridium marker wires for visualization during fluoroscopy

At this time, only the Charite III has been approved for marketing in the United States.

Coverage Decision

Artificial discs are non-covered devices because they are considered investigational and experimental.

Implantations of artificial discs are non-covered procedures because they are considered investigational and experimental.

Billing Codes

Artificial discs do not have unique HCPCS codes at this time. The procedure to implant artificial discs does not have a unique CPT code at this time.

Where is More Information Available?

For more information on coverage decisions, please see:

<http://www.lni.wa.gov/ClaimsIns/Providers/Treatment/SpecCovDec/default.asp>